SECTION 2

MEDICAL TRANSPORTATION

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ATTACHMENT: GENERAL MEDICAL SERVICE Form and Instructions

1 MEDICAL TRANSPORTATION SERVICES

Medical transportation services, that is the transport of a Medicaid recipient from point A to point B for medical services, is a benefit of the Utah Medicaid Program. This SECTION 2 explains the conditions of coverage.

Personal Transportation: A Medicaid client is considered to have **personal transportation** when (1) anyone on the same "case" has a working, licensed personal car, truck, or vehicle, (2) any relative of the "case" living in the same household has a working, licensed personal car, truck or vehicle that can be used for transportation to and from medical services.

If a client does not have personal transportation, they may be authorized for public transportation by their eligibility worker. Vans and taxis may be available where public transportation is unavailable or a qualifying disability exists precluding public transit. If possible, the use of administrative travel, as authorized by the eligibility worker, is appropriate and a preferred means of transportation to medical services.

Determination of personal transportation is primarily determined by PACMIS CAL data. If the information in the computer is, incorrect, updated information should be obtained from the eligibility worker in order to authorize the correct mode of transportation. Decisions for approval and denial are made based on available information.

A qualifying disability must be documented by a physician and be sufficiently severe to render the patient unable to use public transportation or public transportation does not carry the client to within a reasonable distance from the medical service.

1 - 1 Credentials for Transportation Providers

A medical transportation provider must be a Medicaid transportation provider in order to be reimbursed. Some criteria for transportation providers are listed below.

Taxi and van providers must have appropriate local licenses and be qualified under State and local law as transportation carriers. Taxi and van providers must have in their files for audit purposes a copy of each of the following documents:

- Valid Utah Class "D" with Z attachment or a Utah Class "C" Drivers license as required by the Department of Motor Vehicles for the type of vehicle driven.
- Company liability insurance policy for an amount not less that $500,000 per incident and $1,000,000 aggregate. The Utah Department of Health, Attn: DHCF, Bureau of Medicaid Operations shall be named on the insurance as the additional insured.
- Current state registration for each company vehicle.
- Current local business license.

Ground ambulance providers must be licensed by the Utah Department of Health, Bureau of Emergency Medical Services for Ambulance Service Operation.

Fixed wing and helicopter ambulance providers must have a Federal Aviation Administration Air Carrier Operating Certificate and be licensed by the Utah Department of Health, Bureau of Emergency Medical Services for Ambulance Service Operation.

Fixed wing aircraft as common carriers must have a Federal Aviation Administration Air Carrier Operating Certificate.

1 - 2 Verifying Medicaid Eligibility

To ensure the recipient's Medicaid eligibility, **the transportation provider must see the recipient's current Medicaid Identification Card.**

1 - 3 Transportation to Mental Health Services

Most Medicaid recipients receive mental health services and transportation to those services from the community mental health center which has contracted with the Medicaid agency as a Prepaid Mental Health Plan (PMHP). The Medicaid Identification Card states the name of the PMHP in which the recipient is enrolled.

Prepaid Mental Health Plans are responsible to provide transportation to and from mental health appointments. Transportation providers should contact the appropriate Prepaid Mental Health Plan indicated on the recipient's Medicaid card prior to providing non-emergency service to ensure payment. A list of telephone numbers is included with this manual in the General Attachments section. Providers who render emergency transportation must obtain approval from the Prepaid Mental Health Plan within 24 hours of service. Generally, the PMHP stipulates a provider will be reimbursed only when the provider has made a good faith effort to obtain approval from the Prepaid Mental Health Plan within 24 hours of providing emergency services.

Transportation stickers cannot be used for transportation to mental health services.

1 - 4 Clients NOT Enrolled in a Mental Health Plan (Fee-for-Service Clients)

Medicaid recipients who are not enrolled in a Prepaid Mental Health Plan may receive medically necessary transportation to any mental health service covered by Medicaid. Refer to SECTION 1, Chapter 5, Verifying Eligibility, for information about how to verify a recipient's enrollment in a plan.

1 - 5 Monitoring

Medicaid is required to monitor transportation service by reviewing trip tickets to verify appropriateness of travel. This is done on a random basis by requesting all Medicaid trip tickets for a specific period of time.

1 - 6 Record Keeping

Keep trip tickets which have a sticker attached or a prior authorization number on file in the provider's office. These must be made available to Medicaid auditors upon request. Do **NOT** send trip tickets with a sticker attached or a prior authorization number to Medicaid

1 - 7 Suspected Abuse

Please refer cases of suspected abuse of transportation services to Medicaid

1 - 8 Inducements Prohibited

Providers may not engage in any activity which offers trade inducements to clients for choosing a particular provider for the provision of services.

1 - 9 Transportation Broker for Van, Taxi Services

As of June 1, 2001, non-emergency medical transportation by van or taxi is handled by PickMeUp Medical Transport. Medicaid recipients qualifying for transportation must call 1-888-822-1048 for services. The transportation broker does not handle requests for public bus passes or Flextrans. Those programs are not part of the brokered system. Administrative travel continues to be authorized by the eligibility workers.

2 COVERED TRANSPORTATION SERVICES

Medical transportation to obtain covered Medicaid services is a benefit for Medicaid recipients within (1) the limits specified in this chapter for any type of transportation and (2) the limits for the mode of transportation as specified in Chapter 3.

Medicaid reimburses only for the transportation of qualified and eligible Medicaid recipients to and from medical appointments and services. Transportation is covered for "loaded miles" only, that is, with the recipient on board. Miles driven to or from the place where the recipient is picked up are "unloaded miles". Mileage without the recipient on board is not reimbursable.

Transportation must be provided by the most reasonable, cost-effective method consistent with the recipient's physical capabilities, the availability of medical services in the recipient's community, and the availability of transportation services in the community.

All conditions of coverage listed in the remainder of this chapter apply to any type of transportation service.

2 - 1 Transportation to Medicaid-covered Service

Medical transportation is a benefit ONLY to go to and from medical, dental, or other health care appointments, including Managed Care Organization (MCO) services, which are covered by Medicaid. Transportation for MCO services and in-state medical referrals is a covered benefit.

Medicaid does not reimburse transportation to pick up prescriptions at a pharmacy unless the recipient is in route from a medical appointment. New prescriptions should be filled directly after the visit to the prescribing medical practitioner as a segment of that trip. Exceptions to this limitation require prior authorization.

2 - 2 Transportation to Nearest Provider

All medical transportation, in both emergency and non-emergency situations, must be to the nearest Medicaid provider or appropriate facility which can provide the needed services. (Physicians who make referrals to another provider are advised to refer Medicaid patients to the nearest provider or facility which can provide the services required.) For transportation in emergency situations, refer to Chapter 4, *Ambulance Transportation*.

2 - 3 Cost-effective Transportation

Medicaid will authorize the most cost effective transportation in all cases. Medicaid retains the right to determine the most appropriate means of transportation based upon the information provided. Medicaid may allow transportation to a non-provider or for a non-Medicaid-covered service if this is more cost effective.

2 - 4 Inpatient Hospital or Resident of Nursing Facility

Medicaid covers emergency transportation by ambulance for a resident of nursing facility (nursing home). Non-emergency transportation for a Medicaid recipient who is an inpatient in a hospital or a resident of a long term care facility is not a benefit. Refer to Chapters 4 - 2, *Hospital-to-Hospital Transfers*, and 4 - 3, *Ambulance for Residents of a Nursing Facility.*

2 - 5 Patient in Need of Care En Route

Only ambulance transportation includes the care of the Medicaid recipient while in transit. The provider of transportation, such as a taxi or van, may refuse transport if the recipient should have care in route which requires ambulance service.

2 - 6 Prior Authorization for Medical Transportation

If the recipient does not have a Special Medical Transportation Card, or does not have any more transportation stickers, then prior authorization is required for medical transportation by taxicab or van. The need may be for one-time, intermittent, or immediate medical transportation. The provider shall contact Medicaid Information, the Transportation Unit, by telephone to request prior authorization. (The telephone number is included with the General Attachments to this manual.) Authorization must be requested before transportation is provided.

A. For prior authorization, call during the hours stated below:

- Monday, Tuesday, Wednesday and Friday, 8:00 a.m. to noon, 1:00 p.m. to 5:00 p.m.
- Thursday, 11:00 a.m. to noon, 1:00 p.m. to 5:00 p.m.

B. The provider must supply the following information:

- Name of recipient
- Recipient's Medicaid Identification number
- Address of trip origin
- Address of trip destination
- Time and date of transportation

C. Medicaid staff gives the provider the prior authorization number. The provider must enter the prior authorization number on <u>both</u> the trip ticket and the claim presented to Medicaid.

2 - 7 Non-Emergency Transportation for After-Hours Urgent Medical Care

When prior authorization is required for urgent but non-emergency medical transportation (other than an ambulance) during hours* that Medicaid staff cannot issue prior authorization, the transportation provider must obtain authorization **within the next three working days**. For approval, transportation must have been to an emergency care facility, such as emergency room, Instacare, Night Time Pediatrics, or an after-hours clinic. The provider is responsible to ensure the transportation is to an appropriate facility, and the provider must bill using the appropriate modifiers. Otherwise, Medicaid will not authorize the trip, and the claim will be denied.

Hours that prior authorization cannot be issued are:

- Monday, Tuesday, Wednesday and Friday before 8:00 a.m., noon to 1:00 p.m. and after 5:00 p.m.
- Thursday before 11:00 a.m., noon to 1:00 p.m. and after 5:00 p.m.
- Saturday, Sunday
- State and federal holidays

2 - 8 Other Non-Emergency Transportation After Hours

Transportation after hours is transportation occurring before 7:30 a.m. and after 5:30 p.m. Medicaid will not cover after hours transportation, except to urgent care as stated in Chapter 2 - 7 above. This includes dialysis patients who have requested early and late appointments to facilitate dialysis. Dialysis should be scheduled between 8:00 a.m. and 5:00 p.m. to allow transportation during normal working hours. These after hours transportation costs may be the responsibility of the client.

3 SPECIFIC CRITERIA FOR TYPES OF NON-EMERGENCY TRANSPORTATION

Medical transportation benefits include the following types of transport:

- personal transportation
- a UTA bus pass
- special bus services (Flextrans, Handitrans, United Way)
- taxi cab service
- non-specialized van services
- specialized van services
- ambulance transportation

Regardless of the method of transportation, all transportation services are subject to the coverage policy in Chapter 2, Covered Services. The remainder of Chapter 3 gives specific policy for specific types of transportation.

3 - 1 Mileage for Personal Transportation

When no public transportation is available, a Medicaid recipient or a second party who transports the recipient to a covered health care appointment may be reimbursed for mileage through the local Medicaid eligibility office. The recipient must contact his or her Medicaid caseworker in the local Medicaid eligibility office for authorization and reimbursement.
(Utah Administrative code. Human Services. Rule R513-306-606 "Medical Transportation")

Limitation

All transportation services are subject to the coverage policy in Chapter 2, *COVERED TRANSPORTATION SERVICES*.

3 - 2 UTA Bus

Bus transportation is available for a recipient who is currently eligible for Medicaid. Eligible recipients receive a limited UTA bus pass issued by Medicaid with a specific number of rides each month. The bus pass is for MEDICAL TRANSPORTATION ONLY. The pass is to be used ONLY to go to and from medical, dental, or other health care appointments covered by Medicaid.

The bus driver must mark off one of the rides on the bus pass for each trip, subject to the bus transfer policy.

Limitation

All transportation services are subject to the coverage policy in Chapter 2, *COVERED TRANSPORTATION SERVICES*.

Recipient Eligibility for a UTA Bus Pass

UTA bus transportation may be provided for a Medicaid recipient who is able to walk to and from a bus stop. To obtain a pass, the recipient must contact his or her Medicaid eligibility worker.

A. Need and number of rides is determined by the Medicaid worker. The worker must establish that the recipient meets the three conditions listed below:

    1. The person who needs medical transportation is eligible for Medicaid.

    2. The person has an appointment for a health service covered by Medicaid.

    3. The person has no other transportation to get to the medical appointment or obtain service.

B. Bus passes must be mailed and are not immediately available. Mailing takes at least 3 to 5 days to obtain the first bus pass. Subsequent bus passes are mailed to the recipient at the beginning of each month.

C. The bus pass is to be used ONLY by eligible Medicaid recipients to obtain Medicaid-covered services. The bus pass may NOT be used to go to work, school, shopping nor any other place that is not for a medical or dental service, nor to appointments with providers who do not accept Medicaid. If the recipient needs a ride to get to work, school, or places other than the doctor, he should ask the Medicaid eligibility worker for assistance in obtaining a different kind of bus pass.

D. Persons who are not eligible for Medicaid may not use the recipient's bus pass, even if the person is a member of the recipient's family.

E. Recipients are told to let their Medicaid eligibility worker know when they obtain personal transportation and no longer need a bus pass for medical transportation.

3 - 3 Special Bus Services (UTA Flextrans, Handitrans, United Way)

Special bus services are available for residents of Salt Lake, Weber, Davis and Utah counties. In Salt Lake County, the special bus service is *Flextrans*. In Weber and Davis Counties, it is *Handitrans*. In Utah County, it is *United Way*. Eligible recipients receive a Special Medical Transportation Card with peel-off stickers to obtain this transportation service.

The bus provider must check Medicaid eligibility, and the recipient must have a Special Medical Transportation Card with a sticker for each trip. The provider must collect a transportation sticker from the Special Medical Transportation Card to place on the trip ticket. Round trips require two stickers. Each rider must have his/her own Special Medical Transportation Card with a sticker for each trip.

Limitations

A. All transportation services are subject to the coverage policy in Chapter 2, *COVERED TRANSPORTATION SERVICES*.

B. Regular bus passes may not be used for special bus services.

Billing

Providers are encouraged to bill electronically. Refer to SECTION 1, Chapter 11, Billing Claims. If necessary to bill using a paper claim form, use the General Medical Service claim form. A copy of this form and instructions for completing the form are included with this manual. Medicaid requires the use of non-emergency modifiers when billing for services. Refer to Chapter 7 - 4, *Non-Emergency Transportation Procedure Code Modifiers*.

Recipient Eligibility for Special Bus Services

Special bus services are available for residents of Salt Lake, Weber, Davis and Utah Counties, who have a physical inability to use regular bus service and need curb-to-curb services. Before Medicaid can issue a Special Medical Transportation Card for special bus services, the recipient must have previously been approved by the transportation company for special bus services.

Recipients should first contact the local bus service company. The bus company requires the applicant to fill out a form explaining his or her disability. The disability must qualify under the Americans with Disability Act. The bus company will not provide special bus service unless the applicant qualifies.

If the bus company approves a Medicaid recipient for special bus services, the recipient may then report the approval to Medicaid. Medicaid will contact the recipient's physician and document the number of visits needed. Then Medicaid can issue a Special Medical Transportation Card for special bus services with the appropriate number of transportation stickers.

3 - 4 Taxi

Taxicab transportation is available for a recipient who is currently eligible for Medicaid. The taxi provider must check Medicaid eligibility, and the recipient must have a Special Medical Transportation Card with a sticker for each trip. The provider must collect a transportation sticker from the Special Medical Transportation Card to place on the trip ticket. Round trips require two stickers. Each rider must have his/her own Special Medical Transportation Card with a sticker for each trip.

If the recipient does not have a Special Medical Transportation Card, or does not have any more transportation stickers, then the provider must obtain a prior authorization number from Medicaid before transportation is provided. Refer to Chapter 2 -6, *Prior Authorization for Medical Transportation*.

When the need for urgent but non-emergency medical transportation occurs during non-business hours for the Medicaid agency, authorization must be obtained within the next three working days. Refer to Chapter 2 - 7, *Non-Emergency Transportation for After-Hours Urgent Medical Care*.

Limitations on Use of Taxi

A. All transportation services are subject to the coverage policy in Chapter 2, *COVERED TRANSPORTATION SERVICES.*

B. A taxi may not be used to pick up prescriptions at a pharmacy unless in route from a medical appointment. New prescriptions should be filled directly after the visit to the prescribing medical practitioner as a segment of that trip. Exceptions to this limitation require prior authorization.

C. Taxi service is not available to Medicaid recipients in cases of inclement weather, appointment scheduling conflicts, distance from a provider, or lack of funds to take the bus.

Billing

A. Paper Claim Form

Providers are encouraged to bill electronically. Refer to SECTION 1, Chapter 11, *Billing Claims*. If necessary to bill using a paper claim form, use the General Medical Form. A copy of this form and instructions for completing the form are included with this manual. Medicaid requires the use of non-emergency modifiers when billing for services. Refer to Chapter 7 - 4, *Non-Emergency Transportation Procedure Code Modifiers.*

B. Prior Authorization Number

Providers who could not obtain a transportation sticker must place the prior authorization number on the claim.

C. Multiple Riders

If a taxi provider transports more than one recipient to a medical appointment and bills separately for each recipient trip, the provider should bill using the multiple rider code. Refer to Chapter 7 - 1, *Taxi Codes*.

D. Codes

For codes, refer to Chapter 7 - 1, *Taxi Codes.*

Recipient Eligibility for Special Medical Transportation Card with Transportation Stickers

Taxi service is available for a recipient who does not have a private vehicle and either because of disability or physical limitations cannot use the bus, but needs curb-to-curb service. Before approving taxi cab services, Medicaid staff will check vehicle ownership and substantiate medical necessity with the health care provider. The medical need that prevents the recipient from taking public transportation may be temporary (i.e., post-surgery) or permanent (i.e., paraplegic).

3 - 5 Non-Specialized Van Services

Non-specialized van service is available for a recipient who is currently eligible for Medicaid. Non-specialized service generally uses multi-passenger vans, which distinguishes it from specialized van service. The provider of non-specialized van services must check Medicaid eligibility, and the recipient must have a Special Medical Transportation Card with a sticker for each trip.

The provider must collect a transportation sticker from the Special Medical Transportation Card to place on the trip ticket. Round trips require two stickers. Each rider must have his/her own Special Medical Transportation Card with a sticker for each trip.

If the recipient does not have a Special Medical Transportation Card, or does not have any more transportation stickers, then the provider must obtain a prior authorization number from Medicaid before transportation is provided. Refer to Chapter 2 - 6, *Prior Authorization for Medical Transportation*.

When the need for urgent but non-emergency medical transportation occurs during non-business hours for the Medicaid agency, authorization must be obtained within the next three working days. Refer to Chapter 2 - 7, *Non-Emergency Transportation for After-Hours Urgent Medical Care*.

Limitation

All transportation services are subject to the coverage policy in Chapter 2, *COVERED TRANSPORTATION SERVICES*.

Billing

Providers are encouraged to bill electronically. Refer to SECTION 1, Chapter 11, *Billing Claims*. If necessary to bill using a paper claim form, use the General Medical Service claim form. A copy of this form and instructions for completing the form are included with this manual. Note that Medicaid requires the use of non-emergency modifiers when billing for services. Refer to Chapter 7 - 4, *Non-Emergency Transportation Procedure Code Modifiers*.

Multiple Riders

The amount of Medicaid reimbursement for non-specialized van services depends on the total number of recipients being transported on a given trip and the mileage accumulated for each recipient. The billing code used must be based on the most riders the van transported on the given van trip. For example, if only one recipient is transported for the entire trip, then the provider would bill using the code for one rider. If two recipients are transported, then the provider would bill mileage for each recipient using the code for two riders. If three or more recipients are transported, then the provider would bill mileage for each recipient using the code for three or more riders. If a provider picks up a recipient at point A with a destination of D, and along the way, picks up two more recipients at points B and C, the provider may bill separate mileage for each recipient; that is mileage for A to D, B to D, and C to D, for each recipient respectively using the "three or more" rider code.

For codes, refer to Chapter 7 - 2, *Non-Specialized Van Service Codes*.

Recipient Eligibility for Van Services

This service is provided primarily to disabled Medicaid recipients. Under special circumstances, Medicaid may authorize this form of transportation for recipients who are not disabled.

3 - 6 Specialized Van Services

Specialized van service is available for a recipient who is currently eligible for Medicaid. The provider must check Medicaid eligibility, and the recipient must have a Special Medical Transportation Card with a sticker for each trip. The provider must collect a transportation sticker from the Special Medical Transportation Card to place on the trip ticket. Round trips require two stickers.

If the recipient does not have a Special Medical Transportation Card, or does not have any more transportation stickers, then the provider must obtain a prior authorization number from Medicaid before transportation is provided. Refer to Chapter 2 - 6, Prior Authorization for Medical Transportation.

When the need for urgent but non-emergency medical transportation occurs during non-business hours for the Medicaid agency, authorization must be obtained within the next three working days. Refer to Chapter 2 - 7, Non-Emergency Transportation for After-Hours Urgent Medical Care.

Limitations

A. All transportation services are subject to the coverage policy in Chapter 2, COVERED TRANSPORTATION SERVICES.

B. Personal services or emergency medical services are NOT appropriate for these transports and will not be reimbursed.

Billing

Providers are encouraged to bill electronically. Refer to SECTION 1, Chapter 11, Billing Claims. If necessary to bill using a paper claim form, use the General Medical Service claim form. A copy of this form and instructions for completing the form are included with this manual. Note that Medicaid requires the use of non-emergency modifiers when billing for services. Refer to Chapter 7 - 4, Non-Emergency Transportation Procedure Code Modifiers. For codes, refer to Chapter 7 - 3, Specialized Van Service Codes.

Recipient Eligibility for Specialized Van Services

The service is available for recipients who are confined to a wheelchair, other similar durable medical equipment or are otherwise disabled, cannot take a taxi or non-specialized van, and need door-to-door service.

Specialized vans may transport patients who meet one of the following conditions:

a. When the patient has his own oxygen equipment and transports it with the patient who is stabilized and requires no medical attention;

b. When the patient is wheelchair bound;

c. When the patient requires assistance from the van to the home, nursing home, hospital, or clinic;

d. When the patient is stabilized and requires no medical attention, has been approved for the transport by the physician, and there is a responsible person to receive the patient.

3 - 7 Non-emergency Transportation Through Sole Source Contract under a 1915 (b) Waiver

Beginning July 1, 2001, non-emergency transportation is provided by a contractor. Excluded from the contract are: UTA public transportation services contract (buses) AND any other contracts supplying public transportation, such as the UTA Flextrans (wheelchair transport) contract, transportation as stated in Mental Health capitated contract, the Project Reality transportation contract and the Car-A-Van transportation contract.

The contractor may use the most reasonable and economical mode of transportation available appropriate to the recipient's medical condition that is safe and in accordance to state and federal laws.

DEFINITIONS

Curb to curb service means that client has the physical or mental ability to get himself from his residence door to the curb, and/or from the curb or parking lot to the medical facility door, for an appointment *unaided by the driver.*

Door to door service means the client *requires the driver's aid* because he does not have the physical or mental ability to get himself from the residence door to the curb, and/or from the curb or parking lot to the medical facility door for an appointment.

Non-emergency transportation services are available under the conditions listed below.

1. The recipient (hereafter "client") must have a current Medicaid card and be currently eligible for Medicaid services.

2. A client is not eligible for Medicaid transportation services when he or she (a) owns a licensed vehicle or (b) lives in a residence with a family member who owns a licensed vehicle. However, a client may be eligible when a physician verifies that the nature of the client's medical condition or disability makes driving inadvisable, and there is no one at the residence who can drive the client to and from medical appointments.

3. A client is not eligible for Medicaid transportation contractor services if public transportation is available in the client's area, unless it is inappropriate for their medical or mental condition as certified by a physician.

4. A client is not eligible for Medicaid transportation contractor service if paratransit services through public transportation, such as Flextrans, is available in the client's area. However, a client may be eligible when their medical condition requires door to door services because of physical inability to get from the curb or parking lot to the medical provider's office facilities as certified by a physician.

5. A client is not eligible for PickMeUp transportation services, if public transportation is available in the client's area, unless it is inappropriate for his medical or mental condition. He or she may obtain a bus pass from their Medicaid eligibility worker.

6. If a client has a disability or a medical or mental condition that prohibits them from riding the bus, he or she must obtain a physician's certificate indicating the need for transportation.

   A. If the physician's certificate indicates the client can ride the bus, he or she is not eligible for transportation provided by PickMeUp Medical Transport.

   B. If the physician's certificate indicates he or she can use curb to curb service (Flextrans), the client must apply for paratransit services (UTA Flextrans or DART Paratransit in St. George). **If the client qualifies for the paratransit services, he is not eligible for PickMeUp transportation services.** The client may be transported by PickMeUp Medical Transport for up to six weeks while a determination for paratransit services is made.

   C. If the client is denied service by Flextrans or DART, and the physician's certificate indicates he needs door to door service, he may be eligible for PickMeUp services.

D. The client may be transported by PickMeUp Medical Transportation for up to four weeks while the physician's certificate is being obtained. After the four week window, transportation services will be denied if a physician's certificate is not received and on file with PickMeUp.

7. The transportation is limited to obtaining a Medicaid covered medical service.

8. The transportation is limited to the nearest appropriate Medicaid provider.

9. Transportation for picking up prescriptions is not covered unless in route to or from a medical appointment.

10. Destinations outside of Utah are covered up to 120 miles one-way outside of the Utah border. However, the ride must originate or end within Utah borders. Non-emergency transportation originating and ending outside of Utah is not covered.

11. Other applicable provisions of the manual are incorporated into this section including Chapter 6, Noncovered Services.

12. **Urgent care**

A. Urgent care is defined as non-emergency medical care which is considered by the prudent lay person as medically safe to wait for medical attention with in the next 24 hours. Urgent care does not require immediate medical attention. Waiting up to 24 hours will not be life threatening, cause permanent malfunction nor disability. If immediate medical attention is required, it is considered an emergency and should be transported by ambulance.

Transportation for urgent care must not require medical treatment during transit; such transportation must be provided by an ambulance. Usually recipients requesting urgent care will be transported to the nearest provider capable of providing the care, unless otherwise directed by a physician. Use of a hospital emergency room for non-emergency use medical care is strongly discouraged.

B. **Weekdays, business hours – 8:30 AM to 5:30 PM:** Transportation for urgent care is available during weekday business hours of 8:30 AM to 5:30 PM and is commonly provided to the recipient's physician office. If directed by the physician (or if the physician is unavailable), transportation will be to the nearest urgent care facility or walk-in clinic. If an urgent care facility or walk-in clinic is not available, the transport may be to the nearest hospital emergency room. Those clients who have managed care will be transported for urgent care as directed by the plan.

C. **After business hours – 5:30 PM to 11:00 PM:** Transportation for urgent care is available between 5:30 PM and 11:00 PM weekdays to the nearest available urgent care facility or walk-in clinic. Transportation to the nearest hospital emergency room for non-emergency medical care is strongly discouraged and will be provided only if there are no other open medical facilities capable of providing the needed urgent care. Those clients who have managed care will be transported for urgent care as directed by the plan.

D. **Weekends or Holidays – 8:30 AM to 11:00PM:** Transportation for urgent care is available between 8:30 AM to 11:00 PM weekends or holidays to the nearest available urgent care facility or walk-in hours clinic. Transportation to the nearest hospital emergency room for non-emergency medical care is strongly discouraged and will be provided only if there are no other open medical facilities capable of providing the needed urgent care. Those clients who have managed care will be transported for urgent care as directed by the plan.

E. **After 11 PM for all days:** Because it is medically safe to wait, transportation for urgent care after 11:00 PM will be provided the next morning after 8:30 AM and will be provided to the recipient's physician's office unless directed by the physician (or if the physician is unavailable) to an urgent care facility, walk-in clinic, or the nearest hospital emergency room. Transportation to a hospital emergency room for non-emergency medical care will only be made if there are no other open facilities capable of performing the needed medical care. Those clients who have managed care will be transported for urgent care as directed by the plan.

F. **Releases from a Hospital Emergency Room:** Transportation following a release from a hospital emergency room for emergency treatment is covered. Transportation following a release from a hospital emergency room after non-emergency medical care is not covered unless the Medicaid contracted provider or ambulance has provided the transportation to the ER. Those clients who have managed care will be transported as directed by the plan.

13. Weight and Size Limitations

A. If the combined weight of the client and the power wheelchair exceeds the lift capacity as recommended by the lift manufacturer, and the client possess the strength and physical ability to "transfer," aided or unaided, they are not eligible for Medicaid transportation by the Medicaid transportation contractor unless the client is transported in a manual standard wheel chair. Such manual wheelchair may be provided by Medicaid or already be in the possession of the client.

B. If the combined weight of the client and the power wheelchair exceeds the lift capacity as recommended by the lift manufacturer, and the client does not possess the strength and physical ability to "transfer," aided or unaided, as certified by a physician or if they refuse to transfer to an appropriate manual chair, they are not eligible for transportation by Flextrans nor PMU. Medicaid may offer alternate safe transportation, such as an ambulance with the client in a supine position as no other safe transportation means are available.

4 AMBULANCE TRANSPORTATION

Ambulance transportation is the **transport and the medical care** of the patient while in transit. Only ambulance transportation includes the care of the patient while in transit. All transportation services are subject to the coverage policy in Chapter 2, COVERED TRANSPORTATION SERVICES.

Ambulance services (ground, air or water) are covered for transportation in the following circumstances:

A. when the life of the recipient is in immediate danger

B. when life support equipment or medical care is required during travel

C. when other means of transportation would endanger the recipient's health or be medically contraindicated.

Ambulance services may be provided from the recipient's residence or the scene of an accident to the nearest accessible medical facility equipped, staffed and prepared to received emergency cases and administer emergency care appropriate to the needs of the patient.

Medicaid will reimburse for first aid calls when the patient is not transported.

4 - 1 Reimbursement for Ground Ambulance

Program coverage is limited to **base rate billed with the appropriate modifiers, mileage for the loaded ambulance only, oxygen and airway management, and when necessary, waiting time.** Charges for unloaded mileage are **not** reimbursable. Include the appropriate modifiers on the claim as described in Chapter 7 - 6, *Ambulance Procedure Code Modifiers*.

The base rate includes but is not limited to:

a. transportation
b. control of bleeding
c. splinting of fractures
d. treatment of shock
e. CPR and defibrillation
f. re-usable supplies
g. administration of medications: IV, IM, or oral

4 - 2 Hospital-to-Hospital Transfers

1. Prior authorization is required for non-emergency transportation between hospitals for Medicaid-eligible clients.
   A. The transfer must be medically necessary; and
   B. The original hospital must have discharged the client; and
   C. The criteria listed below must also be met.
      (1) The necessary services cannot be obtained at the initial admitting hospital and the transfer is determined to be to the nearest hospital with facilities for appropriate care. This includes both in-state and out-of-state hospitals.
      (2) When a patient is transferred between two hospitals for continuing treatment (the patient remains at Hospital A and is transferred daily to Hospital B for treatment), the transfers are the responsibility of Hospital A. Medicaid will not cover such transfers.
      (3) Medicaid does not cover transport from a hospital capable of treating the patient to another hospital because the patient and/or his or her family prefers a specific hospital or physician.

2. Non-emergency transfers between in-state facilities are covered if the patient is discharged from the originating facility. This includes transfers between long term care facilities and hospitals. Prior authorization is not required. A discharge indicates the facility will not receive the per diem or DRG payments for the dates out of the facility and the patient must be readmitted if returning to the same facility.

3. Prior authorization is required for non-emergency air transportation transfers between institutions. The recipient's medical condition must be such that transportation by either basic or advance life support ground ambulance is not medically appropriate.

4. The medical necessity and reason for transport must be documented by both the discharging hospital and the ambulance provider. Transportation must be to the nearest provider which can provide the needed services. Medicaid reviews these claims on a post-payment basis.

5. Under special circumstances, a recipient may be transferred from a highly specialized hospital (Trauma, Burn, Neonatal, Pediatric Units), after having been stabilized, to a less specialized hospital which is closer to the recipient's home. For example, a child at Primary Children's Medical Center may be transferred to a rural hospital closer to home. Medicaid will decide the appropriate transportation according to the needs of the patient.

Noncovered Ambulance Transportation

1. Round trip ambulance services from one hospital to another hospital or clinic to obtain necessary diagnostic and/or therapeutic services when the recipient remains registered as an inpatient at the originating facility is not covered. The originating facility receives reimbursement for these services under its DRG payment and is responsible to reimburse the transportation provider. A transportation provider may not be separately reimbursed for this type of trip.

2. Ambulance transportation services provided to Medicaid recipients transferring between hospitals, or between a freestanding facility and a hospital, for purposes other than medical need, are not a covered benefit. For example, transfer to another hospital because of the patient's and/or his family's preference, or because a particular physician practices at another hospital, or for convenience, is not a covered benefit.

4 - 3 Ambulance for Residents of a Nursing Facility

Ambulance service is only covered separately by Medicaid for a recipient residing in a long term care facility, nursing home or institution when emergency transportation is required. The ambulance service must be documented as an emergency by the physician or director of nursing.

Non-emergency or routine transportation for a resident of a nursing facility must be provided by the facility in which the person resides.

4 - 4 Billing

Providers are encouraged to bill electronically. Refer to SECTION 1, Chapter 11, *Billing Claims*. If necessary to bill using a paper claim form, use the CMS-1500 claim form. Medicaid requires the use of ambulance modifiers with the base-rate code when billing for services. Refer to Chapter 7 - 6, *Ambulance Procedure Code Modifiers*.

Multiple Riders

If more than one recipient is transported by ambulance from the same point of origin to the same point of delivery in the same ambulance, compute the charges as explained below.

A "full" rate (base rate plus mileage) for the first person, plus fifty percent of said full rate for each additional person.

4 - 5 Air Ambulance

Air transit may be emergency or non-emergency, including fixed wing or helicopter. Air ambulance service is covered in one of four circumstances:

1. The recipient's condition warrants rapid transportation, and the location of the recipient is inaccessible by land vehicle;
2. The recipient must be transported a great distance and time is a factor;
3. The recipient's condition, combined with other obstacles, justifies air (versus ground) ambulance;
4. The cost combined with other factors makes air transport more cost effective.

For rates, refer to Chapter 4 - 7, Air and Water Transit Rates.

Program coverage is limited to **base rate billed with the appropriate modifiers, mileage for the loaded ambulance only, oxygen and airway management, and when necessary, waiting time.** Charges for unloaded mileage are **not** reimbursable. Include the appropriate modifiers on the claim as described in Chapter 7 - 6, Ambulance Procedure Code Modifiers.

4 - 6 Water Ambulance

Water ambulance is covered in two circumstances:

1. the recipient's location is inaccessible by ground or air ambulance, or

2. ground or air ambulance is unavailable.

For rates, refer to Chapter 4 - 7, *Air and Water Transit Rates*.

Program coverage is limited to **base rate billed with the appropriate modifiers, mileage for the loaded ambulance only, oxygen and airway management, and when necessary, waiting time.** Charges for unloaded mileage are **not** reimbursable. Include the appropriate modifiers on the claim as described in Chapter 7 - 6, Ambulance Procedure Code Modifiers.

4 - 7 Air and Water Transit Rates

Air and water transport rates are negotiated with the Medicaid Transportation Policy Consultant at the time of prior authorization for transport using procedure Code A0140, non-emergency air travel.

5 OUT OF STATE MEDICAL TRANSPORTATION, PER DIEM and BORDER TOWNS

1. Out of state transportation:

   Prior authorization is required for non-emergency transportation to and/or from medical services outside the State of Utah, even when the recipient has a referral for the health care service. Medicaid, in consultation with the physician and other medical professionals, decides the most appropriate access to care for the patient. Transportation must be medically necessary and for medical services which are not available within a reasonable distance within the state.

2. Per Diem (In state and within 120 miles out-of-state):

   If out of state transportation is approved and an overnight stay is required outside of a medical facility while receiving Medicaid covered medical services, a per diem to be applied toward the cost of meals and lodging may also be authorized.
   A. When a Medicaid-eligible child requires the out of state services and a parent must be instructed on meeting the medical needs of the child, transportation costs and per diem for meals and lodging may be authorized for one parent to accompany the child.
   B. When there is medical necessity for attendant services, transportation costs and per diem for an attendant may be authorized. A parent or guardian can qualify as the attendant, providing they are able to provide the required services for the patient's demonstrated medical need. Salary may be included if the attendant is not a member of the patient's family. Attendant services are covered only for the period of time the attendant is responsible for hands-on care of the recipient. Stand-by time is not covered.
   C. Per diem payments, to be applied toward the cost of meals and lodging, shall be the lesser of and not exceed $50.

3. Border Towns:

   Transportation to providers in some border towns, though out-of-state, may be considered in-state and covered under the policies of Chapter 2, COVERED TRANSPORTATION SERVICES, and Chapter 3, SPECIFIC CRITERIA FOR TYPES OF NON-EMERGENCY TRANSPORTATION. For clarification of border towns, call Medicaid Information.

5 - 1 Out of State Medical Transportation, Per Diem (Beyond 120 miles of the Utah border)

Transportation for out-of-state medical services is covered if the services are unavailable or cannot be performed in Utah. The transportation is limited to coverage for Medicaid services performed by Medicaid providers and must be prior authorized. The transportation will be the most cost effective, but appropriate for the recipient's medical conditions. If the transportation is within 120 miles of the border it is excluded from this policy, but covered by the transportation contractor for in state transportation.

Transportation covers the recipient and a parent or care giver, if the recipient is a child under the age of 20 years. Transportation may include an attendant for adults age 20 and older, if the recipient's medical condition requires attendant services while out of state. All transportation must be prior authorized.

If commercial transportation by ground or air carrier is used, it will be set up and paid directly by Medicaid. If transportation by personal vehicle is possible and used, the reimbursement is the state rate, or $0.18 per mile. The reimbursement for bus, shuttle, or medically necessary taxi trips to and from the airport, the medical facility, and/or place of lodging are limited to $30 per ride and a maximum cap of $120 per out-of-state medical service visit or trip and receipts must be submitted with the request for reimbursement.

5 - 2 Lodging and Meal Per Diem Associated with Out-of-State Transportation (Beyond 120 miles of the Utah border)

Overnight stays and meals associated with out-of-state travel may be allowed. A per diem for meals and overnight lodging may be authorized for the recipient, except for the days the recipient is receiving inpatient services. If the recipient is a child age 20 years and under, an additional per diem for meals and lodging may be authorized for a parent or care giver. If the recipient is an adult age 18 and older, an additional per diem for meals and lodging may be authorized for the attendant, but only for the days the attendant is giving care and attending to the recipient.

The per diem for lodging and meals will be $25 for lodging and $25 for meals for a total of $50 per day per covered individual. To receive the out-of-state per diem, the Department will require verification of housing and the dates of the days spent out of state for medical services, but receipts for meals are not required. Nights staying with family or friends and associated meals are not eligible for the per diem. Reimbursement for lodging and meals is not available for the parent or care giver during the time the recipient is an inpatient in a medical facility.

5 - 3 Limitations

a. Receipts must accompany requests for reimbursement for lodging and any ground transportation except personal vehicle mileage.
b. Requests for reimbursement for transportation services must be made within one year of the date of the service.
c. All out-of-state transportation, lodging or meals must be prior authorized in order to be reimbursed.

6 NONCOVERED SERVICES

All conditions of Chapters 2, COVERED TRANSPORTATION SERVICES, and 3, SPECIFIC CRITERIA FOR TYPES OF NON-EMERGENCY TRANSPORTATION, must be met in order for Medicaid to reimburse for medical transportation. Medical transportation is not a covered benefit when transportation is requested to obtain services which include, but are not limited to, the following:

A. Day care.

B. School or any educational service.

C. Non-Medicaid providers, unless prior authorized by Medicaid.

D. Non-Medicaid services, unless prior authorized by Medicaid. This includes visitation by relatives to a Medicaid patient in a hospital or other facility.

E. Non-emergency transportation for Medicaid recipients currently residing in a nursing facility or inpatient hospital.

F. Non-emergency transportation for medical services out of the general area of residence where services are available within the area.

G. Transportation covered under the recipient's Prepaid Mental Health Plan.

H. Transportation, either emergency and non-emergency, to providers other than to the nearest provider due to patient preference.

I. Transportation for transplant or triage teams is not covered.

K. Non-emergency transportation for a nursing home patient.

L. Multiple trips for medical appointments on the same day may not be a covered benefit.

M. Obtaining prescription refills at a pharmacy which offers delivery service.

7 PROCEDURE CODES

Reimbursement is made for **loaded miles only**.
Medicaid covers the codes listed in this chapter when billed with the two-letters or two-digit modifiers to indicate origin and destination of transportation. In the 'Comments' column of the code tables, PA refers to prior authorization.

KEY TO DISTINGUISHING CODE CHANGES:
New codes are in bold print.
A vertical line in the margin marks where text was changed or added.
An asterisk (*) in the margin marks where a code was deleted.

7 - 1 Taxi Codes

Taxi Codes	Descriptor	Comments
A0100	Non-emergency Transportation: Taxi, one way	Requires PA, Services provided by Contract only
T2004	Non-emergency transportation; commercial carrier, multiple riders	Requires PA, Services provided by Contract only
A0140	Non-emergency Air Transit/Taxi	Requires PA

7 - 2 Non-Specialized Van Service Codes

7 - 3 Specialized Van Service Codes

Specialized Van Codes	Descriptor	Comments
A0120	Non-emergency transportation, Mini bus, mt. area, other	For use by Flextrans, Handitrans, and DART only
A0130	Non–emergency wheel chair van	Requires PA, Service provided by Contract only
T2001	Transportation attendant or escort	Requires PA, Services provided by Contract only

7 - 4 Non-Emergency Transportation Procedure Code Modifiers

All claims billed to Medicaid for non-emergency transportation **must** have a two-digit modifier. The modifier may be any combination of the single number codes listed below. The first number indicates origin of transportation. The second number indicates destination of transportation.

Location	Code
Recipient's home	1
Hospital	2
Practitioner's office	3
Pharmacy	4
Lab or X-ray	5
Nursing Home	6
Medical Supplies	7
Other	8

7 - 5 Ambulance Codes

Ambulance Codes	Descriptor	Comments
A0420	Ambulance waiting time (ALS or BLS), one half (½) hour increments.	
A0422	Ambulance (ALS or BLS) oxygen and supplies in a life sustaining situation.	Medicaid will reimburse for only one unit of oxygen per emergency transport only when the patient was actually transported.
A0425	Ground mileage per statute mile	*
A0429	Ambulance service, basic life support, emergency transport (BLS-emergency)	*
A0430	Ambulance Service, conventional, air service, transport, one way (Fixed Wing)	*
A0431	Ambulance Service, conventional, air service, transport, one way (Rotary Wing)	*
A0998	Ambulance response and treatment, no transport.	

7 - 6 Ambulance Procedure Code Modifiers

All claims billed to Medicaid for emergency transportation by ambulance **must** have a two-letter modifier. The modifier may be any combination of the one-letter codes listed below. The first letter indicates origin of transportation. The second letter indicates destination of transportation.

Code	Location
D	Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential, domiciliary, custodial facility
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non hospital-based dialysis facility
N	Skilled nursing facility
P	Physician's office
R	Residence
S	Scene of an accident or acute event.
X	(Destination code only) Intermediate stop at physician's office on the way to the hospital.

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